



Member ID# _____ Proposed Effect. Date ___/___/___
 Existing WHP Member ID# (If Applicable) _____

Individual Enrollment Request Form

Please call WHP at 1-800-521-0265 or TTY 1-800-743-3333, 7 days a week, 8 a.m. to 8 .pm. To receive this in large print.

SECTION 1: To Enroll in WHP Medicare Advantage Plans, Please Provide the Following Information:

Please check which plan you want to enroll in:

- Silver (HMO)** (without prescription drug coverage), \$0 per month
- Value Rx (HMO)** (includes prescription drug coverage), \$18 per month
- Silver Rx (HMO)** (includes prescription drug coverage), \$62 per month
- Platinum Rx (HMO)** (includes prescription drug coverage), \$119 per month
- Platinum Select Rx (HMO-POS)** (includes prescription drug coverage), \$205 per month

LAST Name:	FIRST Name:	Middle Initial:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
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Birth Date: (MM/DD/YYYY)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone Number:
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Permanent Residence Street Address (P.O. Box is not allowed):

City:	State:	ZIP Code:	County:
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E-mail Address:

Mailing Address (only if different from your Permanent Residence Street Address):

City:	State:	ZIP Code:	County:
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SECTION 2: Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section.

- Please fill in the blanks at right so they match your red, white and blue Medicare card.
- or -
- Attach a copy of your Medicare card or your letter from the Social Security Administration or the Railroad Retirement Board.

You must have both Medicare Part A & Part B to join a Medicare Advantage Plan.

Name _____	
Medicare Claim Number _____	Sex _____
Is Entitled To:	Effective Date:
Hospital (Part A)	____/____/____
Medical (Part B)	____/____/____

SECTION 3: Choose a Primary Care Physician (PCP) from the plan's Provider Directory

Provider Name:	PCP ID (see directory):
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SECTION 4: Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or by "Electronic Funds Transfer (EFT)" each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. **DO NOT** pay Welborn Health Plans the Part D-IRMAA.

PLAN USE ONLY: Please Do Not Complete This Section

Application Received Date:	Application Entered Date:
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SECTION 4: Paying Your Plan Premium (Continued)

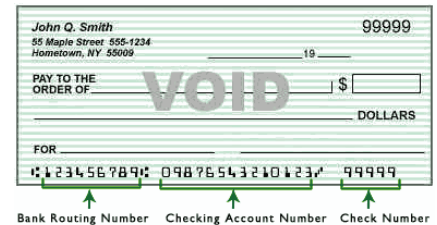
People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

- Get a bill monthly
- Electronic funds transfer (EFT) from your bank account each month.
A VOIDED Check or Deposit Ticket must be included for this option
Account type: Checking Savings
- Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.
(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)



SECTION 5: Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- I am enrolling during the Annual Enrollment Period (AEP).
- I am new to Medicare.
- I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____.
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get extra help paying for Medicare prescription drug coverage.
- I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) _____.
- I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) _____.
- I recently left a PACE program on (insert date) _____.
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.

SECTION 5: Attestation of Eligibility for an Enrollment Period (Continued)

- I am leaving employer or union coverage on (insert date) _____.
- I belong to a pharmacy assistance program provided by my state.
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.

If none of these statements applies to you or you're not sure, please contact Welborn Health Plans at 1-800-521-0265 (TTY users should call 1-800-743-3333) to see if you are eligible to enroll. We are open M-F, 8 a.m. to 5 p.m.

SECTION 6: Please read and answer these important questions:

1. Do you have End-Stage Renal Disease (ESRD)? Yes No

*If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.*

2. Are you a resident in a long-term care facility, such as a nursing home? Yes No
If "yes", please provide the following information:
Name of Institution: _____ Address of Institution: _____ Phone number of Institution: _____

3. Are you currently working? Full-time Part-time Retired N/A

Is your spouse currently working? Full-time Part-time Retired N/A

4. Will you have any **OTHER** insurance besides Welborn Health Plans Medicare Advantage when WHP becomes effective? Yes No (**skip to # 6**)

If "yes" is OTHER coverage through:
 My current / previous employer My spouse's current / previous employer
 Other (**skip to # 5**)

If your coverage is through an **employer** please provide the following information:

Employer name: _____ Phone #: _____

How many employees work for your employer? 1-19 20-99 100 or more Don't know

5. Please provide the following information:

Name of Insurance Company: _____ Phone #: _____

Group #: _____ ID #: _____

Type of coverage: Medical Drug Both Date coverage began: _____ Date coverage ended: _____

6. Do you have VA benefits? Yes No ID# _____

Do you have TRICARE? Yes No ID# _____

Are you enrolled in your State Medicaid Program? Yes No ID# _____

Do you have Hoosier Rx? Yes No ID# _____

Do you have Federal Retirees Coverage? Yes No ID# _____

Date this plan began: _____ Date this plan ended: _____



Please Read This Important Information



If you currently have health coverage from an employer or union, joining Value Rx (HMO), Silver Rx (HMO), Platinum Rx (HMO) and Platinum Select Rx (HMO-POS) could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Value Rx (HMO), Silver Rx (HMO), Platinum Rx (HMO) and Platinum Select Rx (HMO-POS). Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

SECTION 7: Please Read and Sign

By completing this enrollment application, I agree to the following:

Welborn Health Plans (WHP) is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future.

Silver (HMO) ONLY: I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.

Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.

Welborn Health Plans serves a specific service area. If I move out of the area that Welborn Health Plans serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Welborn Health Plans I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Welborn Health Plans when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Welborn Health Plans coverage begins, I must get all of my health care from Welborn Health Plans except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Welborn Health Plans and other services contained in my Welborn Health Plans Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR WELBORN HEALTH PLANS WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Welborn Health Plans he/she may be paid based on my enrollment in Welborn Health Plans Medicare Advantage Plans.

Release of Information: By joining this Medicare health plan, I acknowledge that Welborn Health Plans will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Welborn Health Plans will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

SECTION 7: Please Read and Sign (Continued)

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare

Signature:***Today's Date:**

**If you are the authorized representative, you must sign above and provide the following information:*

Name:

Phone Number:

Relationship to Enrollee:

Street Address:

City:

State:

ZIP Code:

FOR BROKER USE ONLY—Please Do Not Complete the following Section.

Broker Name (Printed):

Broker #:

Agency Name (Printed):

Phone #:

Fax #:

Broker Signature:

Date:



Mail To:
 Welborn Health Plans - Enrollment Dept.
 101 S.E. Third Street
 Evansville, IN 47708

Fax To:
 Welborn Health Plans - Enrollment Dept.
 716-541-6322

Authorization To Release Personal Medical Information

SECTION 1 - Member Information:

Member Name:		Member ID #:
Birth Date: (MM/DD/YYYY)	Age:	Phone Number:
Member Address:		
City:	State:	Zip:

SECTION 2 - I Authorize Welborn Health Plans (WHP) To Release Information To:

Name of Person to Receive Information:		
Relationship to You:	Phone Number:	
Address:		
City:	State:	Zip:
(Optional) Additional Person to Receive Information:		
Relationship to You:	Phone Number:	
Address:		
City:	State:	Zip:

SECTION 2A - Information To Be Released (Please Check a Box Below):

To Assist Me With Regards To Claims and Treatment
 Other: _____

I understand that this authorization is subject to revocation by me (us) at anytime except to the extent that action has been taken in reliance thereon; in which case, I understand that my revocation will not affect the uses and disclosures of such information, which have been before receipt of the revocation. I also understand that any information, which is released pursuant to this authorization, may not longer be subject to the Privacy Rules which otherwise protect the privacy of such information. I also understand that this authorization will expire sixty (60) days from the date signed unless otherwise specified.

SECTION 2B - Choose Your Time Frame (Please Check a Box Below):

_____ (Date, event or condition on which authorization expires if other than sixty (60) days)
 Until I am No Longer Covered Under Welborn Health Plans

SECTION 3 - Please Sign Below:

Member Signature:	Date:
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*If You Are The Authorized Representative, Please Sign Above and Provide The Information Requested Below:

Representative's Name:	Relationship To Beneficiary:
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If signed by an Authorized Representative, this signature certifies that 1) the Authorized Representative is authorized under State Law to complete this form and 2) documentation of this authority is available upon request from Medicare or WHP.